Advance Instruction for Mental Health Treatment

A Guide for North Carolinians

Introduction

You have the right to control the decisions about your medical care. To make these decisions, you must be competent and able to communicate. If you are not competent or able to communicate, someone else must make these decisions for you. Advance instructions allow you to have some control in this situation.

In North Carolina, you may have a general health care power of attorney that covers all health care problems. If you wish, you may also have an advance instruction that covers only mental health care. This publication explains an advance instruction for mental health treatment. For more information on a general health care power of attorney, see the North Carolina Cooperative Extension Service publication, *Health Care Power of Attorney*, FCS-387.

What is an advance instruction on mental health treatment?

An advance instruction on mental health treatment allows you to give instructions and preferences regarding mental health treatment. It also allows you to appoint an agent to make these decisions for you when you are incapable of making them yourself. You must sign the document in the presence of two qualified witnesses. The form provided by §122C-77 of the North Carolina General Statutes is duplicated in this publication. Other forms may be used as long as they comply with the requirements of the statute. If you use a form, read and understand all provisions before signing. Your lawyer can explain and, if necessary, modify the available forms.

Who may make an advance instruction for mental health?

Any person of sound mind who is age 18 or over may make an advance instruction regarding mental health treatment. This person is called the "principal."

When is it effective?

An advance instruction becomes effective when it is delivered to your doctor or other mental health treatment provider. It remains valid until revoked or expired. It automatically expires in two years. If the principal is capable, he or she may revoke the advance instruction at any time in whole or in part. The revocation is effective when the principal notifies his or her doctor or other provider that it is revoked.

What is the doctor's duty?

The doctor must make the advance instruction part of the patient's medical record. The doctor must comply with it to the fullest extent possible, unless compliance is not consistent with

- Best medical practice to benefit the principal,
- Availability of the mental health treatments requested, and
- Applicable law.

If the doctor is unwilling to comply with part or all of the advance instruction for one or more of the reasons stated above, he or she must notify the principal or agent and must record the reason in the patient's medical record.

A doctor need not honor the advance instruction in cases of emergencies or involuntarily committed patients.

How is an agent appointed?

An advance instruction may name a competent adult to act as an agent to make decisions about mental health treatment. An alternate agent may also be named to act as agent if the first choice is unable or unwilling to act. An agent must accept the appointment in writing.

The following people may not serve as the agent:

- The principal's doctor or mental health service provider or an employee of the doctor or provider, if unrelated to the principal by blood, marriage, or adoption.
- An owner, operator, or employee of a health care facility, if unrelated to the principal by blood, marriage, or adoption.

What is the agent's authority?

The agent may make decisions about mental health treatment on behalf of the principal only when the principal is incapable. The principal is incapable when the doctor or psychologist determines that the principal currently lacks the capacity to make and communicate mental health treatment decisions.

The decisions of the agent must be consistent with the desires the principal has stated in the advance instruction. If the principal's desires are not stated in the advance instruction, the agent must act in good faith in the manner in which the agent believes the principal would act if he or she were capable.

What are the agent's rights?

The agent has the same rights as the principal to receive information about the proposed mental health treatment, and to receive, review, and consent to disclosure of medical records relating to that treatment.

The agent may withdraw as agent by giving notice to the principal. If the principal is incapable, the agent may withdraw by giving notice to the doctor or other provider. Notice of withdrawal may be oral, but it is preferable to put it in writing. The doctor or provider must note the agent's withdrawal in the principal's medical record.

What is the agent's potential liability?

The agent is not personally liable, as a result of acting as an agent, for the cost of treatment provided to the principal. The agent is not subject to criminal prosecution, civil liability, or professional disciplinary action for any action taken in good faith pursuant to an advance instruction.

Who may witness it?

An advance instruction for mental health treatment must be witnessed by two people who personally know the principal. Neither may be

- A person appointed as the agent;
- The principal's doctor or mental health service provider or a relative of the doctor or provider;
- The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or
- A person related to the principal by blood, marriage, or adoption.

Conclusion

The advance instruction for mental health treatment became effective in North Carolina on January 1, 1998. Ask your attorney for more information.

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ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. 'Mental health treatment' means the process of providing for the physical, emotional, psychological, and social needs of the principal. 'Mental health treatment' includes electroconvulsive treatment (ECT), commonly referred to as 'shock treatment,' treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that psychoactive medications and electroconvulsive treatment (ECT) (commonly referred to as 'shock treatment') may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed written consent of my legally responsible person, health care agent named pursuant to a valid health care power of attorney, or attorney-in-fact named pursuant to a valid advance instruction for mental health treatment, as required under G.S. 122C-57.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include: _____
_____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows:

I consent to the administration of the following medications: _____
_____

I do not consent to the administration of the following medications: _____
_____

Conditions or limitations: _____
_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

My facility preference is _____

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than 10 days.

Conditions or limitations: _____

_____

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity.

In case of mental health crisis, please contact:

1. Name:
   Home Address:
   Home Telephone Number: Work Telephone Number:
   Relationship to Me:

2. Name:
   Home Address:
   Home Telephone Number: Work Telephone Number:
   Relationship to Me:

3. My Physician:
   Name:
   Telephone Number:

4. My Therapist:
   Name:
   Telephone Number:

The following may cause me to experience a mental health crisis: _____

_____

The following may help me avoid a hospitalization: _____

_____

I generally react to being hospitalized as follows: _____

_____

Staff of the hospital or crisis unit can help me by doing the following: _____

_____

I give permission for the following person or people to visit me: _____

_____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as 'shock treatment'): _____

_____

_____

Other instructions: _____

_____

_____

I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

ATTORNEY-IN-FACT

I hereby appoint:

Name:
Home Address:
Home Telephone Number: Work Telephone Number:

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

Name:
Home Address:
Home Telephone Number: Work Telephone Number:

My attorney-in-fact is authorized to make decisions that are consistent with the instructions I have expressed in this advance instruction or, if not expressed, as are otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interests.

If it becomes necessary for the court to appoint a guardian for me, I hereby nominate my attorney-in-fact to serve in that capacity.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my attorney-in-fact.

Signature of Principal_____ Date_____

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is: (1) A person appointed as an attorney-in-fact by this document; (2) The principal's attending physician or mental health service provider or a

relative of the physician or provider; (3) The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or (4) A person related to the principal by blood, marriage, or adoption.

Witnessed by:

Witness: _____ Date: _____

Witness: _____ Date: _____

STATE OF NORTH CAROLINA

COUNTY OF

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a qualified crisis services professional and a physician or eligible psychologist. I understand that the principal may revoke this advance instruction in whole or in part at any time and in any manner when the principal is not incapable.

Signature of Attorney-in-fact _____ Date _____

Signature of Alternative Attorney-in-fact _____ Date _____